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Filling the Gap in Healthcare Coverage:

How Cities and States Can Bolster Health Insurance Affordability

for Independent Workers and Small Employers

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Filling the Gap in Healthcare Coverage:

How Cities and States Can Bolster Health Insurance Affordability for Independent Workers and Small Employers

by

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Patricia Dawn Hart, MPAff, MBA

The University of Texas at Austin, 2019

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The nature of work is changing in the United States. The emergence of the gig economy and the rise of knowledge work have created new opportunities and challenges for workers. While flexibility has increased over the past decade, with more individuals working when and where they want, wages have remained stagnant and employee benefits — often associated with traditional attachments to work — have moved further out of reach for many working adults. Affording quality health insurance on the individual and small group markets is a major financial burden for independent workers and small employers (companies with 50 or fewer employees). Ideally, federal legislation would be adopted to ensure that the US healthcare policy regime meets the needs of working Americans. Indeed, the passage of the Patient Protection and Affordable Care Act (ACA) of 2010 moved the country closer to such a solution. But the bill was not a panacea. Many consumers earn too much to enroll Medicaid or receive subsidies through the ACA, but not enough to afford quality health insurance on their own. And experts believe recent regulatory action will add to this hardship by raising rates in the individual and small group markets. Cities and states, nevertheless, are well positioned to make quality healthcare coverage more affordable for their residents. These governments also have a lot to

gain by acting, as expanding quality health insurance to more independent workers and small employers is linked to enhanced job creation, workforce productivity, and innovation intensity. Adopting progressive healthcare policies at the sub-federal level could relieve financial stress and improve health outcomes among affected populations.

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Abbreviations

ACA	Affordable Care Act
AHP	Association Health Plan
AMA	American Medical Association
DoL	Department of Labor
EHB	Essential Health Benefits
ERISA	The Employee Retirement Income Security Act
NHI	National Health Insurance
PACE	Protecting Affordable Coverage for Employees
R&D	Research and Development
SHOP	Small Business Health Options Program
TCJA	Tax Cuts and Jobs Act

Introduction

The nature of work is changing in the United States. The emergence of the gig economy and the rise of knowledge work have created new opportunities and challenges for workers. While flexibility has increased over the past decade, with more individuals working when and where they want, wages have remained stagnant and employee benefits — often associated with traditional attachments to work — have moved further out of reach for many working adults. Paying for quality health insurance on the individual and small group markets is a major financial burden for independent workers and small employers, companies with 50 or fewer employees.[1] These workers represent a disproportionate share of the uninsured and underinsured population.[2] In fact, one in five independent workers is uninsured, and they are 1.5 times more likely to be underinsured than those with more traditional employee-employer relationships (42 percent versus 28 percent).[3, 4] At the same time, small employers struggle to afford healthcare benefits for themselves and their workers. Small employers are half as likely as their larger counterparts to offer these benefits, and they face substantial opportunity costs either way.[5]

Ideally, federal legislation would be adopted to ensure that the US health policy regime meets the needs of working Americans. The passage of the Patient Protection and Affordable

[1] The PACE Act of 2016 defines small employers as companies with 1 – 50 employees.

[2] According to The Commonwealth Fund: "a person is underinsured when out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 10 percent or more of household income; or out-of-pocket costs, excluding premiums, over the prior 12 months are equal to 5 percent or more of household income if income is under 200 percent of the federal poverty level ($23,760 for an individual and $48,600 for a family of four); or deductible is 5 percent or more of household income." (Collins).

[3] Sara R. Collins, Herman K. Bhupal, and Michelle M. Doty. "Health Insurance Coverage Eight Years After the ACA," The Commonwealth Foundation, February 7, 2019, website https://bit.ly/2GAEZsT.

[4] David Chase and John Arensmeyer. "The Affordable Care Act's Impact on Small Businesses," The Commonwealth Fund, Oct. 1, 2018, website https://bit.ly/2y9nzyr.

[5] Kaiser Family Foundation. "2018 Employer Health Insurance Benefits Survey," Oct. 2018, website: https://bit.ly/2Qg4y4i.

Care Act (ACA) of 2010 was a step toward such a solution. The legislation extended healthcare coverage to a greater share of the overall population by expanding Medicaid eligibility and establishing subsidies for individuals earning less than 400 percent of the federal poverty level.[6] But the bill was not a panacea. Many consumers earn too much to enroll Medicaid or receive subsidies, but not enough to afford quality health insurance. In addition, the ACA's income-based subsidy system has a steep drop-off, such that earning one dollar over the income cutoff can raise a person's premium by as much as a factor of five.[7] Finally, recent regulatory action will likely raise rates in the individual and small group markets. The repeal of the coverage mandate, which penalized individuals and businesses with more than 50 employees for not purchasing health insurance, is expected to result in a 10 percent increase in premiums over the next three years.[8] Subsidies will insulate those at the financial margins from these price shocks, but independent workers and small employers must either bear the cost increases or drop coverage.

It is important that cities and states examine strategies that could fill the gaps in federal policy by making quality health insurance more affordable for independent workers and small employers. Reform in select states could have an outsized impact in the national healthcare system, as a higher proportion of independent workers and small employers are based in large cities, and more than half of all Americans are projected to live in just eight states by 2040.[9] Local governments that act to make quality health insurance more affordable have a lot to gain.

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[6] Rachel Fehr, Cynthia Cox, et. al. "How Affordable are 2019 ACA Premiums for Middle-Income People?," Kaiser Family Foundation, March 5, 2019, website: https://bit.ly/2NLWEiG.

[7] Ibid.

[8] Molly Frean, Jonathan Gruber, and Benjamin D. Sommers, "Premium Subsidies, the Mandate, and Medicaid Expansion: Coverage Effects of the Affordable Care Act," NBER, May 2017, https://bit.ly/2Wuqz2z.

[9] Philip Bump. "In About 20 Years Half the Population Will Live in Eight States," *The Washington Post,* Aug. 12, 2018, website: https://wapo.st/2PSXtHF.

Affordable health insurance will enable more small employers thrive, driving job creation, productivity, and innovation intensity. Less money going toward healthcare costs also means residents will have more money to pump into the local economy or to invest in their futures. Most importantly, making health insurance more affordable will improve quality of life for individual and families who are currently not offered or cannot afford quality health insurance. It fulfills a fundamental duty of government: to enhance the general welfare of its citizenry.

This report explores the changing nature of work and its effect on the provision of health insurance. Because independent workers and small employers are significant contributors to local and regional economies, the paper argues that helping them afford quality insurance would pay dividends. Action on this front also stands to reduce financial anxiety and produce better health outcomes for those affected. Additionally, the report examines how recent federal regulation has affected the individual and small group health insurance markets and describes how cities and states can fill gaps in federal regulation. The paper concludes with considerations and recommendations for public officials aiming to make individual and small group health insurance more affordable.

The Advent Employer-Sponsored Healthcare

In the first half of the 20th Century, employer-sponsored health insurance was far from inevitable. Public policy decisions meant to contain runaway wages during World War II gave rise to the system. The draft caused severe labor shortages, and employers began increasing pay to compete for talent, creating worry among economists that wage increases might spiral out of control and cause widespread inflation. To manage these risks, President Franklin D. Roosevelt froze wages in 1942 through Executive Order 9250.[10] But businesses found a loophole in fringe benefits. The most common benefit offered was health insurance, in part because employer spending on health insurance became tax exempt in 1943, making the benefit more cost effective.[11] The booming post-war economy also contributed to the rise of employee-sponsored health insurance because unions were well positioned to negotiate benefits. In 1960, two-thirds of the US population had healthcare coverage through their employers, up from nine percent just two decades earlier.[12] By 2018, employer-sponsored healthcare plans insured over 152 million people in the US, roughly half of all non-seniors.[13] Health insurance, meanwhile, has grown to become a $955 billion industry.[14]

[10] Aaron E. Carroll. "The Real Reason the US has Employer-Sponsored Health Insurance," *The New York Times*, Sep. 5, 2017, website: https://nyti.ms/2j15rle.

[11] Ibid.

[12] Ibid.

[13] Kaiser Family Foundation. "2018 Employer Health Insurance Benefits Survey."

[14] *IBIS World*. "Health & Medical Insurance Industry in the US," Dec. 2018, website: https://bit.ly/2DPzYu9.

The Future of Work and Employer-Based Healthcare

The employer-based healthcare system is ill-suited for an economy where traditional workplace ties are in decline. The system also contributes to the difficulty small employers face hiring and retaining workers. Small employer challenges associated with the employer-based healthcare system are compounded by an upsurge of knowledge work, which has increased the relative importance of human capital.

Emergence of the Gig Economy

The gig economy refers to the prevalence of temporary, flexible jobs where companies rely on independent workers instead of full-time employees.[15] Bolstered by emergence of the gig economy, there has been a rise in the number of independent workers in the US. In fact, nearly 25 million nonfarm workers filed returns as sole proprietors in 2014, representing a 34 percent increase over 2001.[16] Indeed, one estimate suggests that gig positions comprise up to 16 percent of the workforce.[17] Companies in the gig economy, like Uber, Postmates, and Airbnb, often use sophisticated technology platforms to hire independent workers for gig jobs. The gig job category, nevertheless, is much broader than those provided by application-enable businesses, and may include workers in professional fields, such as adjunct and part-time professors.

Companies in the gig economy rarely offer healthcare benefits to independent workers, as these workers can purchase health insurance on the individual market. For the average full-time gig worker, the individual market is affordable because their premium costs are partially subsidized (assuming these workers are aware of the subsidy program). But, many independent

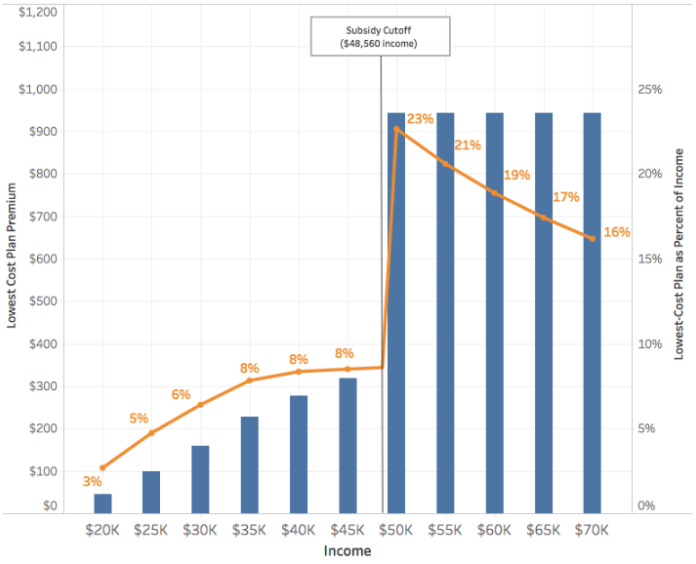
[15] Prudential Insurance, "Gig Workers in America: Profiles, Mindsets, and Financial Wellness," Feb. 2017, website: https://bit.ly/2YdNkId.

[16] Emilie Jackson, Adam Looney, et. al. "The Rise of Alternative Work Arrangements: Evidence and Implications for Tax Filing and Benefit Coverage," The Department of the Treasury, Jan. 2017, website: https://bit.ly/2ZRrnAs.

[17] Prudential Insurance.

workers earn too much to receive financial assistance and too little to afford quality health insurance. According to Prudential Insurance, the income of full-time gig workers tends to increase with age, and the mean age of full-time gig worker is 47 years old. On average, Millennials (ages 18-35) earn $27,500 annually, while Gen Xers (ages 36-55) earn $36,300 annually and Boomers (ages 56+) earn 43,600 annually.[18] At these incomes, most full-time gig workers are eligible for some subsidies to help pay for monthly premiums. For a silver plan, Millennials would pay seven percent of their gross income; Gen Xers would pay nine percent; and Boomers would pay eight percent. But the "subsidy cliff" kicks in at $48,560, affecting roughly half of all boomers who are full-time gig workers. For a Boomer who earns one dollar over the income cutoff, silver plan costs almost triple, increasing from 8 percent to 23 percent of their gross annual income.[19]

Figure One: Average Silver Plan Premium (by Income, Age, and Metal Level, 2019)



Source: Kaiser Family Foundation. "How Affordable are 2019 ACA Premiums for Middle-Income People?"

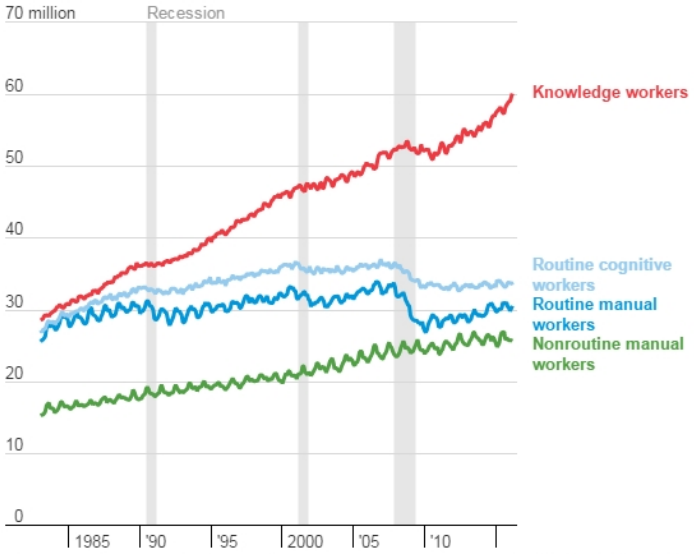
[18] Ibid.

[19] Rachel Fehr, Cynthia Cox, et. al. "How Affordable are 2019 ACA Premiums for Middle-Income People?" Kaiser Family Foundation, Mar 05, 2019, website: https://bit.ly/2NLWEiG.

Rise of the Knowledge Worker

Knowledge work refers to "systems of consumption and production that rely on intellectual capital."[20] Researchers estimate that roughly 35 percent of US workers are knowledge workers, and that share is expected to grow to 40 percent by 2020.[21] While firms of all sizes employ knowledge workers, these workers tend to be concentrated in certain industries that are dominated by small employers. For example, the Small Business Association notes that industries containing the largest share of small employers are professional, scientific, and technical services.[22] This would indicate that success for many small employers is a function of being able to recruit and retain human capital.

Figure Two: The Rise of Knowledge Workers



Source: Data — The St. Louis Federal Reserve; graphic — Wall Street Journal

[20] Will Kenton. "Knowledge Economy," *Investopedia*, April 14, 2019, website: https://bit.ly/2VRzQkC.

[21] Tim Hansen. "The Future of Knowledge Work," Intel Corporation, 2014, website: https://bit.ly/2V0A1ca.

[22] US Small Business Administration. "Firm Size Data."

Because job seekers prioritize health insurance benefits, small employers are at a competitive disadvantage when it comes to talent. According to a recent poll by Moster.com, over 86 percent of job seekers say that affordable health insurance is important when deciding whether to take a new job. Only eight percent of respondents said they do not think it is important, while five percent do not feel strongly either way.[23] This finding is echoed by small employers. An eHealth survey of companies with 30 or fewer employees found 6 in 10 respondents say offering health insurance facilitates the recruitment and retention of employees.[24] The survey also found that offering health insurance may cause small employers to make budget cuts in other areas, which may hurt retention. Approximately 60 percent of respondents said the cost of offering health insurance has inhibited their ability to offer their employees raises and bonuses.[25] According to these small employers, this expense also causes them to delay hiring.

[23]Stacy Rapacon. "How to tell if your employer's health insurance benefit is any good," Monster, website: https://bit.ly/2WqG5wc.

[24] eHealth.

[25] Ibid.

The Role of Independent Workers and Small Employers

Independent workers and small employers play an important role in local and regional economies. These companies drive job creation, productivity, and innovation intensity. Responsible for roughly half of all new job creation, small companies generated almost 1.5 million new jobs in 2015 (the last year for which data was available).[26, 27] Small employers are also associated with productivity growth in the overall economy, even though they may be less productive on a per employee basis than larger firms. The Organization for Economic Cooperation and Development (OECD) explains:

> *Overall productivity changes occur because individual firms raise their productivity levels and because they expand and displace low-productivity firms. Similarly, new entrants replace exits because they have a higher level of productivity. As [small employers] account for most of the entrants, exits, growth and decline, they form an integral part of a competitive process that contributes significantly to aggregate productivity growth — even if at any particular time, their level of productivity is below that of larger firms.*[28]

The conventional wisdom is that small firms are more innovative than their than their larger counterparts; it is theorized that innovation decreases with firm size because of bureaucracy. This idea is supported by data about patent attainment and the creation of new product lines by firm size. Indeed, firms with fewer than 500 employees (96.4 percent of which

[26] Small Business Administration. "2018 Small Business Profile," 2018, website: https://bit.ly/2NS3WUk.

[27] Fred Imbert. "Job gains in 2015 were strong, but…," *CNBC*, Jan. 11, 2016, website: https://cnb.cx/2H1xLxL.

[28] OECD. "Small Businesses, Job Creation and Growth: Facts, Obstacles and Best Practices," website: https://bit.ly/2gnxE2U.

are small employers) generate roughly 27 patents per employee, while firms with 500 or more employees produce fewer than 2 patents per 100 employees.[29, 30, 31] But when looking at the other measures of innovation, the impact of firm size on innovation is far more complex. For example, large firms spend more on Research and Developments (R&D) and implement different R&D strategies than small companies, generating different types of innovation.[32]

Larger firms tend to pursue incremental innovation, whereas smaller firms are more likely to peruse radical — or intense — innovation. Accordingly, larger firms may have more versions of a product, while small employers are more apt to launch completely new products. When controlling for innovation intensity, innovation is a function of scale. Nevertheless, small employers help stretch R&D dollars regardless of the entity making the investment. These firms create virtuous cycles for between-aggregate R&D spending and innovation, as they capitalize on "spillover pools," information produced by larger public and private organizations.[33] Large firms, on the other hand, tend to rely more on their own R&D, potentially missing out on opportunities for radical innovation.[34]

Another way in which independent workers and small employers contribute to the economy is by advancing the success of larger companies. Independent workers and small employers play a vital role in the value chains of larger companies. For example, small employers are essential to the supply chains of manufacturers. Indeed, US automakers rely on

[29] Anthony Breitzman and Patrick Thomas. "Analysis of Small Business Innovation in Green Technologies," US Small Business Administration, 2011, website: https://bit.ly/2WxcqBm.

[30] US Small Business Administration. "Firm Size Data," 2018, website: https://bit.ly/1VqWlrO.

[31] Breitzman.

[32] Anne Marie Knott and Carl Vieregger. "All Hail Large Firm Innovation: Reconciling the Firm Size and Innovation Debate," Washington University, March 12, 2015, website: https://bit.ly/2DQd2eh.

[33] Ibid.

[34] Ibid.

roughly 1,700 suppliers for component parts — many of which are small employers.[35] Likewise, many companies operating in the gig economy would not exist without the labor of independent workers. This group also delivers a panoply of business-to-business services, including financial, legal, and technological services that enable larger companies to focus more their core competencies, furthering specialization which is linked to productivity gains.[36]

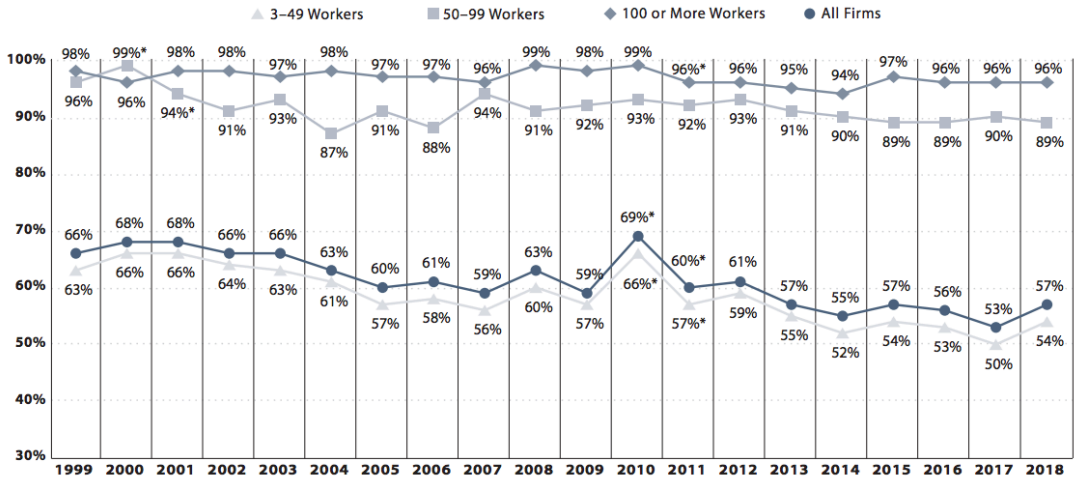
[35] University of Minnesota. "The Importance of Small Business to the U.S. Economy," website: https://bit.ly/2ZR71Yh.

[36] Sean Ross. "What are the economic impacts of specialization?," Investopedia, Nov. 19, 2018, website: https://bit.ly/2WkDlQU.

Purchasing Power in Health Insurance Markets

As with R&D, large companies likewise have a competitive advantage over small employers in the health insurance market. Even though most business owners would like to offer healthcare benefits, only about 54 percent of small employers provide their workers with health insurance.[37] In contrast, roughly 92.5 percent of businesses with 50 or more employees off healthcare benefits to their workers.[38] The primary barrier for small employers offering health insurance is its high and instable costs. Consequently, many small employers choose not to offer healthcare benefits, requiring their workers to purchase insurance on the individual market — if they purchase it at all. Women-owned business are disparately impacted these issues because they are more likely than their male counterparts to be small employers.

Figure Three: Percentage of Firms Offering Health Benefits, by Firm Size, 1999-2018



Kaiser Family Foundation. "2018 Employer Health Insurance Benefits Survey."

[37] Kaiser Family Foundation. "2018 Employer Health Insurance Benefits Survey," Oct. 2018, website: https://bit.ly/2Qg4y4i.

[38] Ibid.

Firm Size and Risk Pooling

The fundamental concept underpinning insurance is risk pooling. In health insurance, a risk pool refers to a set of individuals whose medical costs are combined to establish premium costs for the entire group. Those with lower medical costs in a risk pool offset the expense of those with higher medical costs. The premiums of larger groups tend to be more stable than those of smaller groups, given the high costs associated with an unhealthy person are more likely to be offset by the low costs associated with a healthy person when more people in group. But small group premiums are not intrinsically more expensive than that of large groups. The premium for a small group with many healthy members may have lower costs than that of a large group with many unhealthy members.[39] Nevertheless, it is often the case that small groups have greater per person costs than large groups because they do not have sufficient negotiating power with insurers, and they may lack the capital to self-insure.

High and Instable Costs of Small Group Plans

The National Federation of Independent Businesses (NFIB) has found the cost of health insurance to be the number one challenge small businesses face since 1986.[40] According to the Kaiser Family Foundation, the average annual premium for employer-sponsored health insurance in 2018 was $6,896 for single coverage and $19,616 for family coverage.[41] Small employers pay an average of 8 to 18 percent more than large firms for the same coverage.[42] In tandem with employers, workers tend to contribute toward premium costs. On average, workers with

[39] American Academy of Actuaries. "Risk Pooling: How Health Insurance in the Individual Market Works," July 2017, website: https://bit.ly/2H2as72.

[40] Holly Wade. "Small Business Problems and Priorities," National Federation of Independent Business, Aug. 2016., website: https://bit.ly/2R183ez.

[41] Kaiser Family Foundation. "2018 Employer Health Insurance Benefits Survey."

[42] National Conference of State Legislatures. "Small and Large Business Health Insurance: State & Federal Roles," Sept. 12, 2018, website: https://bit.ly/2p6U3nY.

employer-based health insurance pay 18 percent of premium costs for single coverage and 29 percent of premium costs for family coverage. But, in recent years, employees have taken on a larger share of premium costs, especially for family plans. Over the past decade, premium rates for family coverage increased by 55 percent, and the amount paid by workers increased by 65 percent over the same time, far outpacing wage growth.[43]

Most companies pay an insurance carrier a fixed premium for their healthcare plan, commonly referred to as fully-insured plans. But roughly a third of companies have self-insured plans. Under this model, employers pay healthcare expenses out-of-pocket and forgo the monthly premium costs. It is estimated that companies save roughly 30 percent in administrative costs when they self-insure.[44] Nevertheless, self-insurance tends to be best suited for large employers because assuming the risk of paying healthcare claim requires financial resources. Small employers tend to have smaller cash flows and less capital than large firm. Therefore, self-insurance is far less likely to be a viable option for these companies. Despite the extra administrative costs, fully-insured small employers are subject to state health insurance premium taxes — typically 2-3 percent of the premium's dollar value.[45]

The smallest employers are hit hardest by the steep and rising cost of healthcare benefits. A survey by eHealth found that about three-quarters of businesses with 30 or fewer employees say they are somewhat or very concerned about being able to continue to provide insurance due

[43] Kaiser Family Foundation. "Key Facts about the Uninsured Population," Dec. 7, 2018, website: https://bit.ly/2WmdpV2.

[44] PL Yong, RS Saunders, and LA Olsen. "The Healthcare Imperative: Lowering Costs and Improving Outcomes: Workshop Series Summary," Institute of Medicine Roundtable on Evidence-Based Medicine, 2010, website: https://bit.ly/2H470sB.

[45] SIIA. "Self-Insured Group Health Plans," website: https://bit.ly/2Y4VlPH.

to rising costs.[46] Nearly two-thirds of firms with 30 or fewer employees say that a 15 percent increase in premiums would cause them to drop coverage.[47] At the same time, these employers face high variability in costs, as variance is inversely correlated with firm size.

Enrollment in small group plans has declined in recent years, given these market dynamics. Small group plans covered 17.4 million Americans in 2012. In four years, enrollment in small group coverage dropped to 13.6 million.[48] While this trend is a continuance of that seen before the passage of the ACA, the legislation may have hastened the decline in the small group market because the individual market operates as a substitute good for small employers that are not required to provide their employees with health insurance benefits. Nevertheless, the healthcare plans obtained on the individual market are often of poorer quality than that of small group coverage. According to The Commonwealth Fund, most small employers that provide health insurance benefits offer comprehensive coverage, while over 90 percent of plans purchased on the individual market are lower-quality silver and bronze healthcare plans.[49]

Disparate Impact on Women Entrepreneurs

Women entrepreneurs are disparately impacted by health insurance costs. Although women account for a mere one-third of all business owners, 99.9 percent of woman-owned businesses are also small businesses — two-thirds of which are run by women of color.[50] On average, companies owned by women are smaller, younger, and lower-income than male-owned

[46] eHealth. "Small Business Health Insurance: Costs, Trend and Insights 2017," April 2018, website: https://bit.ly/2qWvtr5.

[47] Ibid.

[48] Mark A. Hall and Michael J. McCue. "The Health of the Small-Group Insurance Market," The Commonwealth Fund, Oct. 29, 2018, website: https://bit.ly/2JhPdQa.

[49] Ibid.

[50] Michael McManus. "Women's Business Ownership: Data from the 2012 Survey of Business Owners," US Small Business Administration, May 2017, website: https://bit.ly/2sk6Sys.

businesses. Roughly 95 percent of women-owned businesses have 20 or fewer employees. Consequently, the expense of small group health insurance plans affects almost all female entrepreneurs. And the tradeoffs employers make when deciding whether to provide healthcare benefits may be more complex for female business owners than male owners. Women are more likely than men to have a child as a dependent, and more than half of women have a pre-existing condition.[51] These factors add to the relative importance of providing quality coverage with family options, which may be a lower priority for their male counterparts.

[51] Theresa Chalhoub and Aditya Krishnaswamy. "Moving Backward: Efforts to Undo Pre-Existing Condition Protections Put Millions of Women and Girls at Risk," Center for American Progress, June 21, 2018, https://ampr.gs/2KjGTNs.

Impact on Affected Populations

Independent workers, small employers, and small employer workers account for a disproportionate share of uninsured and underinsured Americans. This population is significantly more likely than those with adequate coverage to experience financial problems linked to medical costs and to forgo needed healthcare.

The Uninsured

Working age adults account for roughly 85 percent of the 24 million people who are uninsured in the US.[52] Cost is the main reason cited for not having insurance. Almost three quarters of uninsured workers say they do not have access to an employer-based plan. Among those who are offered coverage, 90 percent say they cannot afford the premiums.[53] One in five people who are uninsured report that they have gone without needed care, while about half have no regular source of care.[54] Studies have shown these factors reduce use of preventative services and chronic disease management, driving poorer health outcomes.[55] There are also financial consequences to not having insurance. More than half of the uninsured population report having unpaid medical bills, and almost 10 percent file for bankruptcy.[56, 57]

[52] Kaiser Family Foundation. "Key Facts about the Uninsured Population."

[53] Ibid.

[54] Ibid.

[55] Ibid.

[56] Sara R. Collins, Munira Z. Gunja, and Michelle M. Doty. "How Well Does Insurance Coverage Protect Consumers from Health Care Costs? The Commonwealth Fund, Oct. 2017, website: https://bit.ly/2YcwI3I.

[57] Ibid.

The Underinsured

In 2016, more than a quarter of working age adults were underinsured (41 million people).[58] Apart from the Medicare population, the underinsured rate is highest (44 percent) among those who purchase coverage on the individual market. High deductibles, which are common on the individual market, drive medical debt among the underinsured. The average deductible for a Bronze plan on the healthcare exchanges is $5,700; while Silver plans have an average deductible of $3,000.[59] Among the underinsured, 52 percent of those with high deductible plans report having medical bill problems or debt — only two percent lower than that of the uninsured. Medical bills and debt are linked to financial hardship for this population. Half of the underinsure who have debt report wiping out their entire savings to pay off medical bills. At the same time, the underinsured are twice as likely as their adequately insured peers to skip treatment recommended by doctor because of the expense.[60]

[58] Ibid.

[59] Michelle Andrews. "Hunting for a Health Plan for 2017? Bronze May Be Your Best Value," *NPR*, Nov. 3, 2016, website: https://n.pr/2vKALrL.

[60] Collins.

Regulatory Action on Health Insurance

Since its inception, the provision of health insurance has been a perianal issue in American politics. The advent of the industry can be traced back to the Great Depression when hospitals began providing medical services on a pre-paid basis, evolving into BlueCross organizations in the 1930s. Multiple administrations have sought to expand healthcare coverage to more individuals and families over the past century. These public policy efforts and decades of health insurance industry growth have secured coverage for more than 90 percent of Americans in 2018.[61] This section explores the journey taken by policymakers to get to this point.

National Health Insurance Act

Since the presidency of Harry S. Truman, business, labor, and provider interest groups have been some of the most powerful forces shaping public opinion on healthcare reform. Their influence first became clear when Truman proposed the development of a National Health Insurance (NHI) program, his signature public policy proposal during his 1948 campaign. Labor was split in its support for NHI, but business, led by the Chamber of Commerce, stood in stark opposition to the plan. Together with the American Medical Association (AMA), the business community characterized the NHI as "socialist medicine," comparing the plan to programs in China and Germany where communism was on the rise.[62] They were effective in their efforts to erode public support for the NHI proposal, which was ultimately abandoned in the wake of the Korean War.[63]

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[61] Kaiser Family Foundation. "Key Facts about the Uninsured Population."

[62] Kaiser Family Foundation. "National Health Insurance: A Brief History of Reform Efforts in the US," March 2009, website: https://bit.ly/2PKr9GO.

[63] Truman Library and Museum. "President Truman's Proposed Health Program," website: https://bit.ly/2qyllD8.

The Health Security Act

Health insurance coverage accounted for roughly 12 percent of the economy by the 1990s, as increases in premium outpaced inflation.[64] To rein in these costs, the Clinton Administration proposed The Health Security Act that sought universal coverage through employer and individual mandates, competition between private insurers, and government oversight to keep costs down.[65] While some in the business community came to accept the need for healthcare reform, smaller companies opposed the measure on the basis of the coverage mandate. The NFIB and the AMA led the opposition to The Health Security Act, running a largescale effort to sway public opinion through a congressional letter writing campaign, television advertisements, and media coverage asserting that the mandates would place too great a financial burden on small businesses and lower-middle class families. The Health Security Act died in Congress in 1994, but the Clinton Administration still managed to pass incremental reforms like the Child Health Insurance Program.

The Obama Administration

President Barack Obama ushered in the culmination of multiple attempts over several decades to fundamentally transform the US healthcare system. The expansion of healthcare coverage was a central policy proposal for Obama during 2008 campaign. And, after two years of committee meetings, negotiations, and votes, The Patient Protection and Affordable Care Act (ACA) was passed and signed into law in 2010. Experts described the 2,000+ page bill as one of

[64] Ibid.

[65] Ibid.

the most complex pieces of legislation ever passed.[66] This section focuses on major provisions of ACA and other regulatory changes that occurred under the Obama Administration.

The Patient Protection and Affordable Care Act

Prior to the adoption of the ACA, small employers and independent workers accounted for a disproportionate share of the uninsured, as six in 10 uninsured people were self-employed or employees of a business with fewer than 100 employees.[67] Fast forward almost a decade, and small employer workers account for roughly half of all ACA marketplace enrollees, as more nearly 6 million have signed up for coverage.[68] Indeed, the ACA has provided coverage to 20 million people who were previously uninsured.[69] These gains were achieved through health insurance exchanges, market regulations, coverage mandates, and Medicaid expansion.

The ACA established a system of state and federal health insurance exchanges: online marketplaces where people can compare and purchase healthcare plans. Several states set up their own marketplaces, while the federal government established marketplaces in states that declined to institute such exchanges. These marketplaces have been instrumental in helping independent workers gain coverage. Before the legislation was passed nearly 30 percent of self-employed workers lacked insurance, but the number fell to approximately 20 percent in 2016.[70] In fact, small employers and independent workers are three times more likely than other consumers to purchase health insurance through an ACA marketplace.[71]

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[66] Alice M Rivlin. "Implementing the Affordable Care Act: Why is This So Complex?," The Brookings Institute, July 8, 2013, website: https://brook.gs/2IYdcV1.

[67] Ibid.

[68] Ibid.

[69] Chase.

[70] Ibid.

[71] Ibid.

The ACA also put in place a set of requirements for insurers regarding plan access and quality. The bill made it illegal for insurers to charge higher rates to people with preexisting conditions or to discriminate against enrollees based on health status, gender, or industry type. Additionally, the ACA set quality control standards, requiring plans to meet minimum standards called essential health benefits (EHBs). The ACA also required insurers to allow children to remain on their parent's insurance until they are 26-years-old. While data is limited, logic suggests that allowing young adults to stay on their parent's health insurance may reduce the uninsured rate among employees of small enterprises because working for a small employer is one of the first experiences many people have when they enter the workforce.[72]

The ACA required individuals to attain healthcare coverage through its coverage mandate, whether through an employer or the individual marketplace. Companies with more than 50 full-time employees must provide health insurance for their workers, and there is non-compliance penalty for those choosing not to offer health benefits. The goal of these mandate was to reduce the cost of premiums by signing up younger, healthier people who would effectively reduce the overall cost of health insurance by offsetting the cost of older, less healthy enrollees.

Business interests were generally opposed to the ACA, due to the mandate that companies with 50 or more full-time employees provide their workers with health insurance benefits. In the 2012 US Supreme Court case "National Federation of Independent Business v. Sebelius," the NFIB challenged Congress's authority to enact a mandate to buy health insurance. The Court ruled in a 5-4 decision that the mandate was constitutional under Congress's taxing power. However, the Court took issue with how the law expanded Medicaid as an improper use

[72] Small Business and Entrepreneurship Council. "Facts & Data on Small Business and Entrepreneurship," 2016, website: https://bit.ly/2FAXRZF.

of Congress's spending power. The ACA required states to expand Medicaid or forgo pre-existing Medicaid funding from the federal government, and thee Court concluded that states must be permitted to opt-out of Medicaid expansion.

Medicaid expansion, under the ACA, allows children and adults with incomes at 138 percent of the federal poverty level to enroll in Medicaid.[73] For example, an individual making up to $16,600 would be eligible for to participate in Medicaid, but only in states that expanded the program. As of 2018, 36 state had expanded to program.[74] In these states, uninsured rates have been halved, declining from about 20 percent to 10 percent since the ACA was adopted.[75] Many of those who gained coverage through Medicaid expansion are small employer workers. According to Center on Budget and Policy Priorities, an estimated 1.7 million small business employees gained coverage through the expansion of Medicaid.[76] The share of small business workers who receive coverage through Medicaid increased from about 9.1 percent in 2013 to 13.4 percent in 2016.[77]

Non-expansion states had worse coverage outcomes. These states saw their uninsured rates drop from 22.7 percent to 19 percent over the same period, approximately one-third of drop seen by expansion states.[78] In many ways, states that have not expanded Medicaid have added to the burden of small employers in their state. In addition to cost constrains and human capital concerns, small employers may also have a less productive workforce as fewer employees have

[73] Larisa Antonisse, Rachel Garfield, et. al. Kaiser Family Foundation, "The Effects of Medicaid Expansion under the ACA," March 28, 2018, website: https://bit.ly/2ONti7f.

[74] Kaiser Family Foundation. "Status of State Action on the Medicaid Expansion Decision," Nov. 26, 2018, website: https://bit.ly/2ONti7f.

[75] Chase.

[76] Ibid.

[77] Ibid.

[78] Ibid.

access to healthcare. Medicaid can support small employers, even those that have their own plans, because workers who are not offered or cannot afford employer-sponsored benefits have other options.

Labor and business interests have played a big role in the Medicaid expansion debate. Labor generally supports building onto Medicaid and Medicare as a strategy for promoting universal coverage. The AFL-CIO has repeatedly urged state lawmakers who have yet to adopt Medicaid expansion under the ACA to do so as soon as possible.[79] Business was largely opposed to the ACA, but it is ambivalent on the issue of Medicaid expansion. The NFIB opposes Medicaid expansion, while the US Chamber of Commerce has no position. Business associations at the state level have been split on the issue. Large business groups in Missouri, Texas, Idaho, Virginia, Alaska, Pennsylvania, and Tennessee support Medicaid expansion, while the chambers of commerce in North Carolina and Georgia oppose it.[80]

SHOP Marketplaces

The ACA created the Small Business Health Options Program (SHOP) to address some of the challenges small employers face in the health insurance market. Through SHOP marketplaces at both federal and state level, small employers can compare and purchase healthcare plans. A small employer with 25 employees or fewer may qualify for the Small Business Health Care Tax Credit which covers up to 50 percent of a small employer's annual premium costs.[81] Unfortunately, there is no publicly available information on tax credit uptake.

[79] AFL-CIO. "Resolution 6: Making Health Care for All a Reality," Oct. 24, 2017, website: https://bit.ly/2J5a1v1.

[80] Phil Galewitz. "Business Groups Split on Medicaid Expansion," *Kaiser Health News*, March 10, 2014, website: https://bit.ly/2VN5KCb.

[81] National Conference of State Legislators.

Regulating Association Health Plans

Association Health Plans (AHP) allow small employers to band together to purchase health insurance. AHPs have the potential to reduce costs for their members because they provide the group with greater negotiation power with insurers in addition to making self-insurance more financially feasible. Consisting of six percent of employers with 250 or fewer workers in 2018, this market is expected to grow precipitously over the next several years.[82] Despite their capacity for growth and potential for reducing the cost of healthcare coverage for small employers, AHPs have long been mired in scandals and instances of fraud and insolvency. Given their reputation, the Obama Administration took several steps to regulate AHPs. In 2013, the Department of Labor (DoL) set new standards for AHPs, requiring they be bound together by a "commonality of interest" beyond simply sharing the same health plan. The guidelines also restricted the ability of independent workers for joining AHPs, though these plans were still permitted to withhold coverage based on health status.[83]

PACE Act

The Protecting Affordable Coverage for Employees (PACE) Act was adopted in 2015. The bill amends provisions the ACA and Public Health Service Act to revise the federal definition of "small employers". While business with 1 – 100 employees were previously considered small employers; the PACE Act redefines small employers as companies with 1 – 50

[82] Kaiser Family Foundation. "2017 Employer Health Benefits Survey," Sept. 19, 2017, website: https://bit.ly/2H9ZTxF.

[83] US Department of Labor. "MEWA Under ERISA a Guide to Federal and State Regulation, Aug. 2013, website: https://bit.ly/2zIAwRt.

employees.[84] States were provided the option to extend the definition of small employers to companies with 1 – 100 employees. In California, Colorado, and New York elected to expand the definition of small employers to include businesses with up to 100 workers, increasing the number of small groups able to participate in SHOP plans.[85]

The Trump Administration

President Donald J. Trump has taken several steps to roll back the ACA and other regulatory action taken by the Obama Administration. Leading up to his election in 2016, Trump had run on the Republican's "repeal and replace" message, an ode to dismantling the ACA and establishing a new law. But in 2017, Republicans in Congress failed to secure the votes needed to repeal the bill.[86] This section describes other actions taken by the Trump Administration affecting the health insurance market.

Tax Cuts and Jobs Act

The Tax Cuts and Jobs Act (TCJA) passed Congress and was signed into law in December 2017. The bill made several changes to how individuals and corporations are taxed. It also repealed the ACA's mandate penalties (the ACA still requires citizens to have health care coverage, but the penalty was adjusted to $0), which experts believe will reduce some of the gains made under the ACA to expand insurance coverage and increase uncompensated care.[87] Researchers at the CBO have estimated that the repeal of individual mandate penalties will cause a 10 percent increase in the cost of premiums for fully-insured plans, as healthier individuals are

[84] CMS. "Frequently Asked Questions on the Impact of PACE Act on State Small Group Expansion," Oct. 19, 2015, website: https://go.cms.gov/1PHcXsQ.

[85] Hall.

[86] Julie Rovner, "Timeline: Despite GOP's Failure to Repeal Obamacare, The ACA Has Changed," Kaiser Health News, April 5, 2018, website: https://bit.ly/2zt3hlB

[87] Sherry Glied. "Implications of the 2017 Tax Cuts and Jobs Act for Public," American Public Health Association, June 2018, website: https://bit.ly/2vCRPzM.

more likely to drop their health insurance coverage.[88] The premium increases will affect all fully-insured employer-sponsored healthcare plans, but small employers will be hit hardest. As previously noted, roughly two-thirds of small employers with 30 employees or fewer said that a 15 percent increase in rates would cause them to drop their coverage.[89]

The TCJA had other downstream affects for the healthcare industry. The plaintiffs in Texas v. Azar challenged the constitutionality of ACA without the coverage mandate penalty. Because the TCJA had eliminated the penalty associated with the coverage mandate, Texas district court judge Reed O'Connor passed down a ruling that the ACA would no longer be permissible under the Congress's taxes power. Thus, he ruled the entire ACA unconstitutional, arguing that the individual mandate is an essential and inseverable part of the ACA. O'Conner, however, did not immediately invalidate the ACA; rather, the law will stay in place in all 50 states and the District of Columbia until the ruling works its way through the Fifth Circuit Court of Appeals.[90]

Repealing the ACA without a replacement would have a dramatic impact on the entire healthcare system. In the wake of O'Connor's ruling, the Democratic party and several legal experts came out against the decision. Yale law professor Abbe Gluck, who submitted an amicus brief in Texas v. Azar, argued that O'Conner had disregarded settled legal doctrine and ignored Congress's choice not to repeal the ACA in 2017. According to Gluck:

> *It's absolutely ludicrous to hold that we do not know whether the 2017 Congress would have wanted the rest of the ACA to exist without an enforceable mandate, because the*

[88] Ibid.

[89] eHealth.

[90] Katie Keith. "Federal Judge Strikes Down Entire ACA; Law Remains in Effect," *Health Affairs*, Dec 15, 2018, website: https://bit.ly/2EwR54S.

2017 Congress did exactly that when it zeroed out the mandate and left the rest of the ACA standing. He effectively repealed the entire Affordable Care Act when the 2017 Congress decided not to do so. [91]

While initially declining to defend the whole of O'Conner's decision, the Department of Justice (DoJ) switched gears in 2019, aligning with the judge's position that the ACA in its entirety must be repealed.[92] The fate of the ACA is still unclear, despite the broad implications of its repeal.

Further Regulating Association Health Plans

After Trump signed an executive order for the expansion of AHPs in 2017, the DoL released a rule that created a different set of standards that AHPs could follow, depending on state law. The Commonwealth Fund describes these two sets of rules (that set by the Obama Administration and that set by the Trump Administration) as "two pathways."[93] An APH could follow the rules of "new pathway" if the state that they operate in has not passed state regulation affirming the rules of the "old pathway." The new pathway varies from that established by the Obama Administration, as it makes it easier for AHPs to gain single employer status given they will no longer be subject the "commonality of interest" provision.[94] Additionally, the rule allows independent workers to join AHPs, while adding the requirement that associations cannot discriminate based on health status. It also provides AHPs with "broad discretion" over health plans by exempting them from EHBs standards. An Avalere Health projection indicates the new

[91] Devlin Barrnett. "Legal experts rip judge's rational for declaring Obamacare law invalid," *The Washington Post*, Dec. 15, 2018, website: https://wapo.st/2J66tYv.

[92] Ricardo Alonso-Zaldivar. "Trump's battles with Obamacare moves to the courts," *The Associated Press*, March 31, 2019, website: https://bit.ly/2UYGPqJ.

[93] Kevin Lucia, Justin Giovannelli, et. al. "In the Wake of New Association Health Plan Standards, States Are Exercising Authority to Protect Consumers, Providers, and Markets," The Commonwealth Fund, Nov. 27, 2018, website: https://bit.ly/2RCHoWl.

[94] Erica Teichert and Susannah Luthi. "Judge strikes down association health plan rule as ACA runaround," Modern Healthcare, March 28, 2019, website: https://bit.ly/2TJjjxs.

rule would cause premiums would rise in the current individual (2.7% to 4.0%) and small group (0.1% to 1.9%) markets over the next five years.[95]

Twelve states led by New York and Massachusetts sued over the new AHP rule. Two major points of contention were the provisions that 1) allows small employers and independent workers to band together simply for health insurance; and 2) enables these entities to skirt EHB standards. Plaintiffs have argued in court that the goal of the AHP rule was to undermine the individual marketplace. Ultimately, Judge John D. Bates of the District Court of the District of Columbia ruled in favor of the plaintiffs and vacated the new rule. "The final rule was intended and designed to end run the requirements of the ACA, but it does so only by ignoring the language and purpose of both ERISA [Employee Retirement Income Security Act] and the ACA," Bates wrote.[96] The DoL has indicated it will appeal the ruling.[97]

[95] Dan Mendelson and Chris Sloan. "Association Health Plans Projected to Enroll 3.2 Million Individuals," Avalere Heath, Feb 28, 2018, website: https://bit.ly/2UYEewZ.

[96] Keith.

[97] US Department of Labor. "U.S. Department of Labor Statement Relating to The U.S. District Court Ruling in State of New York V. United States Department of Labor," April 26, 2019, website: https://bit.ly/2WcQkUB.

Making Quality Health Insurance More Affordable

Improving the economics of individual and small group health insurance plans is an opportunity for cities and states to cultivate stronger entrepreneurial ecosystems. By equalizing power across firms of different sizes, governments can reduce the incumbent advantage of large firms; thus, making young and small firms more competitive. Indeed, researcher have noted that *not* favoring incumbent firms in public policy is a forerunner for entrepreneurial ecosystems. This section explores considerations for policymakers as they look to improve the economics of individual and small group health insurance plans. It concludes with recommendation for public officials at the state and city level.

Alternative Models for Individual and Small Group Coverage

The ACA helped broaden access to health insurance for independent workers, small employers, and small employer workers. According to The Commonwealth Fund:

> *More than 5.7 million small-business employees or self-employed workers are enrolled in the ACA marketplaces; more than half of all ACA marketplace enrollees are small-business owners, self-employed individuals, or small-business employees.*[98]

Despite these gains, as many as 65 million independent and small employer workers do not have quality health insurance. And, if policymakers do not act quickly, more and more workers will join the ranks of uninsured and underinsured population.

One strategic lever policymakers could employ to reduce costs of health insurance for local small employers are SHOP plans, which can reduce premium costs for small employers by as much as 50 percent. Eighteen states run SHOP marketplaces, including Mississippi and Utah that only run SHOP exchanges. While there is a dearth of information on the performance of the

[98] Chase.

federal SHOP marketplace, enrollment at the state level has lagged expectations. Collectively, 144,000 individuals are covered by states-run SHOP plans.[99] But there is wide range of variability across states. While New York and California have each enrolled over 3,600 groups, covering 42,000 individuals, some states have only enrolled 200 or fewer small employers.[100] Some of the states with low rates of enrollment like Vermont and Hawaii are considering dissolving their SHOP exchanges altogether.

Enrollment in SHOP plans is influence by a range of factors, including how states define small employers, the delivery systems states choose for enrollment, how federal incentives are structured, and education and awareness. Some states expanded the definition of small employers to include companies with 1 – 100 employees, double the federal definition. While there are far more companies with 1 – 50 employees, those with 51 – 100 employees are more likely to offer employee benefits. They also tend to have stronger cash flows than their smaller counterparts. Accordingly, companies with 51 – 100 employees may self-select into SHOP coverage, effecting higher rates of uptake in New York, California, and Colorado. How plans are sold also affect uptake, as two of the five states that do not offer an online platform for businesses to sign up for SHOP coverage are considering dissolving their SHOP marketplaces.[101] These states sell SHOP coverage through brokers that small business owners must be aware of to enroll. According to a 2017 survey by The Commonwealth Fund, 40 percent of uninsured working age adults were not even aware of the existence of ACA exchanges.[102] Thus, it is unlikely that high proportion of

[99] Emily Curran, Sabrina Corlette, and Kevin Lucia. "State-Run SHOPs: An Update Three Years Post ACA Implementation," The Commonwealth Fund, July 29, 2016, website: https://bit.ly/2GYlKba.

[100] Ibid.

[101] Ibid.

[102] Shanoor Seervai. "Cuts to the ACA's Outreach Budget Will Make It Harder for People to Enroll," The Commonwealth Fund, Oct. 11, 2017, website: https://bit.ly/2Y6CyUg.

uninsured business owner are aware of SHOP coverage, which has garnered far less attention. Another barrier for SHOP uptake is that the tax credit for eligible small employers can only be realized at tax season. Small employers must cover the full cost of premiums for a calendar year before attaining the tax benefit.

AHPs represent another potential strategy for equalizing purchasing power in health insurance. AHPs are increasingly being explored as a private sector solution; but opinions vary on the ultimate value of this approach, as demonstrated by how states reacted to the new AHP rule. Some states welcomed the new standards, while some fought it in the courts. Several states placed additional requirements on APHs beyond the federal standards, ensuring the regulatory landscape will vary from state to state.[103] Most state regulation on this front was erected to protect consumers, providers, and/or health insurance markets, although states took different approaches in pursuit of those ends.[104] For example, California and Washington State prohibited the formation of new AHPs in the wake of the new rule, while New York, Indiana, and several other states simply required associations to satisfy EHB standards before entering health insurance market.[105]

The main argument against leveraging the AHP model to expand coverage is that it could undermine the individual market for health insurance by reducing the customer pool, but small risk pools do not necessarily mean premiums will rise. Some are concerned that healthier independent and small employer workers might opt for less expensive coverage through AHPs, causing premiums to increase in both the individual and small group markets. But there are a

[103]David McFarlane, Meredith Parnell, and Michelle Chipetine. "Taking the Pulse of New Association Health Plans," Jan 2, 2019, website: https://bit.ly/2GZP6pn.

[104] Ibid.

[105] Ibid.

range of steps that states can take to ensure the integrity of the individual market. Setting restrictions on targeting healthier consumers is a good place to start. Ensuring an even regulatory playing field among insurance provider — whether an association or not — could help reduce market volatility. Moreover, third party administrators could play an important role in AHP development by aligning incentives between association payers and members.

Recommendations for Public Officials

Creating affordable, quality healthcare options for small employers and independent will require complementary policy at all levels of government and cross-sector cooperation. This section describes policies and strategic levers state and local governments and private entities can employ to address some of the challenges small employers and sole proprietor face attaining and maintaining health insurance.

Educate and Reach Out: Establish public-private partnerships to educate small employers and sole proprietors on SHOP coverage and individual plans. Financial investments in education and outreach programing are needed at the state and local level, including navigators who help consumers find coverage. This is especially important as the Trump Administration has cut the funding for these activities. Some states have already taken the lead in this effort. New York has established an extensive, state-funded navigator program that is associated with an increase in the insured rate among ethnic and racial minorities.

Establish clear regulations for AHPs: Proactively regulate AHPs at the state level while federal AHP standards are working their way through the courts. In particular, states should enact policy to protect consumers from fraud or insolvency. Some states have already taken a lead in this area by requiring APHs to exist for a reason other than to provide health insurance or to have been in existence for a set period of time before offering health insurance to members,

and some have required that APHs be fully-insured. Regulation should also aim to find a balance between encouraging choice and protecting the viability of the individual marketplace. Several states have passed regulation that independent workers cannot purchase through an AHP, but regulators would be wise to consider whether it should be the responsibility of independent workers to maintain the viability of the individual health insurance market. If it is, they may want to consider expanding subsidy opportunities for independent workers.

Establish online SHOP marketplace: Create online platforms so small employers can purchase health insurance, improving the rate of participation in the small group health insurance market. Several states have not set up SHOP marketplaces for small employers to purchase coverage and gain access to tax credits. Consequently, many small businesses must purchase SHOP coverage at the federal level which may cost more and be less suited to the health profile of a particular state than plans offered by state-run marketplaces. Other states have established off-line SHOP marketplaces where small employers must purchase from brokers. Creating an online platform where small employers can purchase health insurance could improve the rate of participation in the small group health insurance market. An online distribution system may be particularly important for enrolling millennials — a target market given that age is inversely correlated with health status — who are joining the ranks of entrepreneurs at increasing rates.

Institute a trust to provide SHOP tax credits to small employers at enrollment: Institute trusts that disburse a proportion of the tax benefits to small employers at the time of enrollment at the state and city level. States and cities could then establish mechanisms to recoup the funds when taxes are due. Young and small companies are less likely than their more mature and larger counterparts to have strong cash flows with which to cover the cost of monthly premiums. While the tax credit offered to companies with 25 or few employees is meant to offset the expense of

small group plans, receiving the benefit on the backend may lessen ability of small employers to enroll in SHOP coverage. States and cities should consider instituting trusts that disburse a proportion of these tax benefits at the time of enrollment. They could establish mechanisms to recoup the funds when taxes are due.

Expand Medicaid Coverage: Expand Medicaid coverage in the 14 states that chose not to participate in Medicaid expansion should adopt the program, whether through legislation or ballot initiative. Policymakers in these states often praise small businesses, but their decision to reject the expansion puts small employers and independent workers at an economic disadvantage compared to their counterparts in expansion states. Texas, for example, has highest uninsured rate in the country. It also has one of the most restrictive Medicaid systems. Texas Medicaid only covers people with disabilities who have incomes below 75 percent of the federal poverty level, pregnant women with incomes less than 200 percent of poverty, and parents with incomes less than 19 percent of poverty.[106] If Texas were to participate in Medicaid expansion, 600 thousand Texans would gain coverage.[107] Further, the state would receive more than $100 billion in federal funding over the next decade.[108] Other non-expansion states also stand to gain if they were to adopt the program. In 2016 alone, non-expansion states left nearly $43 billion in federal funds on the table.[109]

Institute a single-payer system or public option: Not all states have populations large enough to establish a single-payer system, but some do — and should. California is leading the

[106] Louise Norris. "Texas and the ACA's Medicaid expansion," Health Insurance Resource Center, Oct. 15, 2018: https://bit.ly/2xK2lqE.

[107] Ibid.

[108] Ibid.

[109] Stan Dorn, Megan McGrath, and John Holahan. "What Is the Result of States Not Expanding Medicaid?," Urban Institute, Aug. 2016, website: https://urbn.is/2VNW0aI.

charge, as the state requested leeway from the federal government to create a single-payer system. Perhaps more practical for most states is Washington State's proposals to establish a public option health plan to compete with private insurers. Given the fact that the state has no profit motive, a public option could reduce costs for the individual market, making it more appealing to independent workers. States could also offer a public option for small group plans that could be sold through SHOP marketplaces.

Conclusion

The healthcare system fails a large segment of the US population. It is commonplace for independent workers to earn too much to receive ACA subsidies for purchasing health insurance, but not enough to afford it on their own. At the same time, small employers struggle to provide healthcare benefits for themselves and their workers, and face substantial opportunity costs either way. Consequently, independent workers, small employers, and small employer workers are disproportionately represented among the uninsured and underinsure population, which is expected to grow given employment trends and new regulation at the federal level. National legislation be should adopted to address the coverage needs of working Americans. But until such a bill is passed into law, it is critical that we adopt interim solutions at the city and state level. Local governments should consider the following policies and practices aimed at expanding quality health insurance to uninsured and underinsured individuals:

- Educate and Reach Out
- Establish clear regulations for AHPs
- Establish online SHOP marketplace
- Institute a trust to provide SHOP tax credits to small employers at enrollment
- Expand Medicaid Coverage
- Institute a single-payer system or public option

In the end, comprehensive healthcare will require cross-sector cooperation and complementary policies at all levels of government. Cities and state are well positioned to lead on these issues, which would foster greater health and wellness, financial wellbeing, and entrepreneurship among the residents of their cities and states. By stepping up to ensure that access to healthcare is not a function of where someone works, local governments help actualize the American axiom that if you work hard, you will get ahead.

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